Wyoming Department of Health

Commit to your health.

BEHAVIORAL HEALTH DIVISION

Participant Guide

Comprehensive Waiver

Behavioral Health Division
Developmental Disabilities Section
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Hello,

I'm Joe Simpson, the Administrator for the Developmental Disabilities Section of the Behavioral Health Division. I am excited to share more information with you about the new and improved waiver program, now called the Comprehensive Waiver. The vision for this new waiver, as developed by a citizen stakeholder committee, is to promote truly person-centered services for participants to have more independence, find and maintain employment, increase relationships and be more outcomes-based.

Why did we make this waiver change? In March 2013, the Wyoming Legislature passed Senate Enrolled Act 82, a law requiring Wyoming Department of Health, Behavioral Health Division (BHD) to develop two new waivers - ***Supports Waiver and Comprehensive Waiver.*** *The new law required us to "optimize the services provided to current clients and to extend appropriate services to persons currently on a waiting list for waiver services within the current budget."*

We know moving away from the familiar waiver to a new one can be uncomfortable. We have worked with many case managers and providers, participants, advocates and family members in order to make changes to services and the waiver program that will better serve our Wyoming citizens into future. I think you will be pleased with the new services provided and the focus on improving our service delivery system. Please take a moment to walk through this guide that explains the new waiver program.

Thank you,

Joe Simpson

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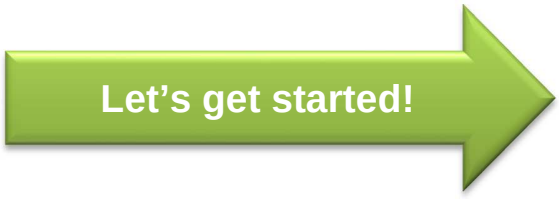

Let’s get started!

Introduction to the Waiver

Waiver Programs

Waivers are programs that waive certain restrictions of the State Medicaid Plan to allow the Wyoming to fund additional services not covered by another paid or unpaid source. The goal of the waiver program is to support an individual in his or her own community, provide services for people with a higher level of service need and help avoid the need for institutional care. The Behavioral Health Division administers this waiver for Wyoming.

This guide provides the necessary information, forms, and procedures to assist an individual in understanding the Comprehensive Waiver purpose, processes and services.

Comprehensive Waiver Mission

The Comprehensive Waiver provides services to eligible persons of all ages with intellectual and developmental disabilities with a higher level of service need than the Supports Waiver. Waiver services help an individual actively participate in the community with friends and family, be competitively employed, and live as healthy, safe, and independently as possible in the least restrictive setting. Services and supports are person-centered and honor one's own choices and preferences.

What Do You Want for Your Life?

What Do You Want for Your Life?

The Comprehensive Waiver should help you achieve it!

At an advocacy conference, Dr. K. Charlie Lakin along with other researchers, state directors of services, state and national advocates, parents of children with disabilities and people with disabilities, the participants were asked to identify:

What is it that people ought to be getting out of service?

and

What is it that people with disabilities want to accomplish with our support?

Source: http://www.camphill.org/files/symposium.pdf

People want more control. They want other people to respect that their homes are their homes. They want to be the ones who control their own front door, their refrigerator, and all their own stuff.

People want to live with people with whom they chose to live. Most particularly, they want to be free to not live with people they do not like, people who hurt, intimidate, and otherwise prevent them from feeling at ease at home.

People want to be able to choose and have help to participate in activities that they like and that they feel good about. They want to have more choices. They want to have more variety in what they can do.

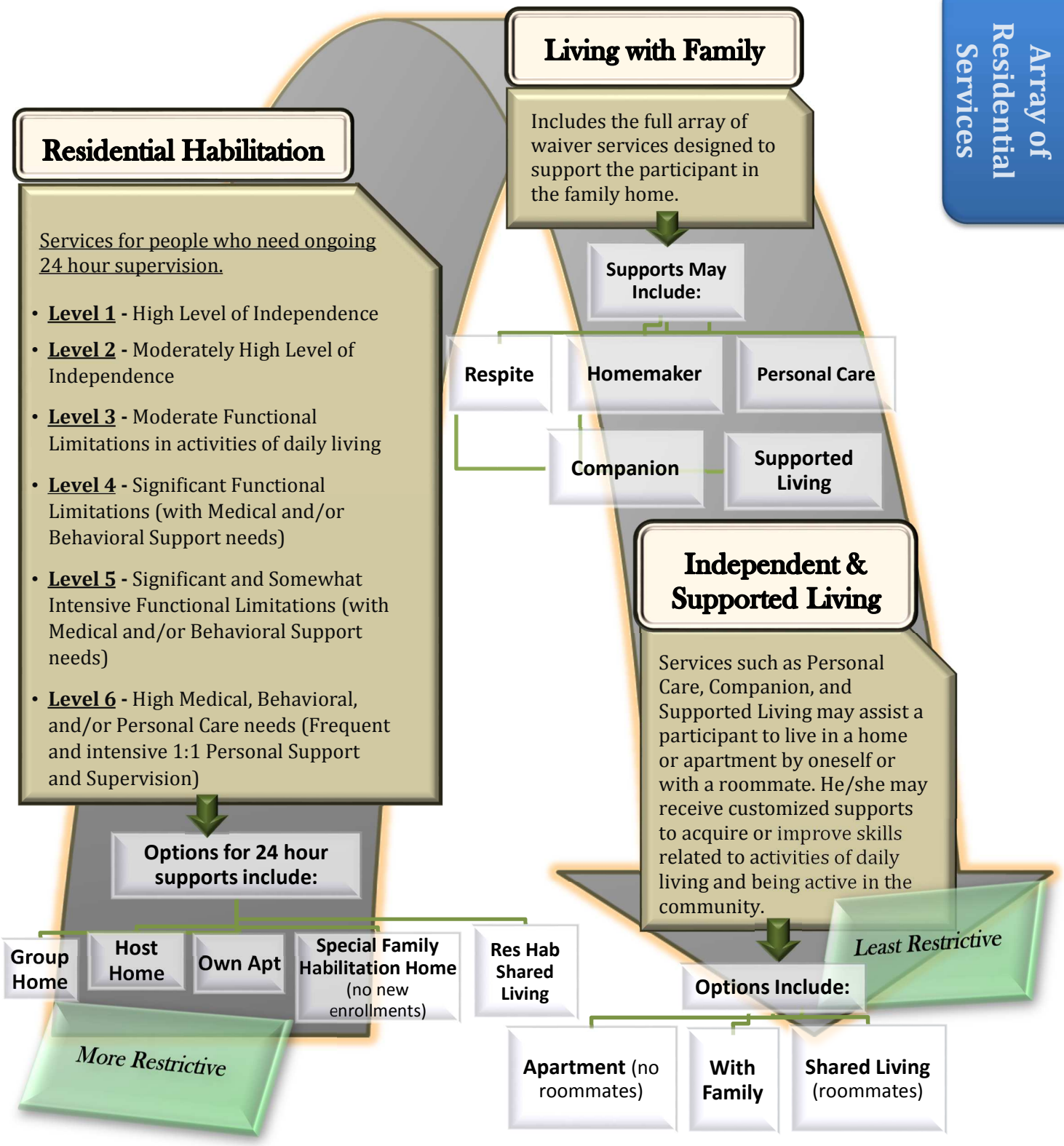
People want to earn money. They want jobs with pay, to work more hours and earn more money than they currently do.

People want to contribute to their community. They want to feel acceptance and personal value from what they do.

People want to be listened to. They want to be listened to when things are being planned for them. They want to be asked how things are going in their lives. People want to be asked if they like their services.

We want the waiver to help you achieve these things!

An Array of Services Available to Support the Least Restrictive Setting Possible



Comprehensive Waiver Services

Traditional Services	*Self-Directed Services
Case Management *(& Subsequent Assessment)*	
Adult Day Services *(must be over 21)*	
Behavioral Support Services	
Child Habilitation Services *(must be under 18)*	Child Habilitation Services *(must be under 18)*
Cognitive Retraining	
Community Integration Services	
Companion Services *(must be 18 or older)*	Companion Services *(must be 18 or older)*
Dietician Services	
Environmental Modifications	
Employment Discovery and Customization	
Homemaker	Homemaker
Independent Support Broker	Independent Support Broker
Individual Habilitation Training *(must be under 21)*	Individual Habilitation Training *(must be under 21)*
Personal Care	Personal Care
Physical, Speech, & Occupational Therapy *(must be under 21)*	
Prevocational *(must be 18 or older)*	
Residential Habilitation *(must be 18 or older)*	Res Hab Shared Living *(must be 18 or older)*
Respite	Respite
Skilled Nursing	
Special Family Habilitation Home *(under 21 only)*	
Specialized Equipment & Supplies	Self-Directed Goods & Services
Supported Living Services *(must be 18 or older)*	Supported Living Services *(must be 18 or older)*
Supported Employment *(must be 18 or older)*	Supported Employment *(must be 18 or older)*
Supported Employment Follow Along *(must be 18 or older)*	* Self-Direction Handbook is available at DD Section website: www.health.wyo.gov/ddd
Transportation	

Service Options

Please refer to page 38 for Service Descriptions

Clinical Eligibility Requirements

Comprehensive Waiver Eligibility

To be eligible for the Comprehensive Waiver, all of the following are required and will be checked annually:

Eligibility Comprehensive Waiver

1. Is a legal United States citizen
2. Is a Wyoming resident as determined by the State Medicaid Agency
3. Meets ICF/IID level of care
4. Meets Financial Eligibility as determined by the State Medicaid Agency
5. Meets one of the following clinical eligibility diagnoses:
   - **If a related condition**, medical verification is required by a licensed physician and a licensed psychologist confirms that the related condition meets the definition of a developmental disability as determined by substantial functional limitation in three or more of the areas of major life activity.

A Related Condition

Is attributable to a mental or physical impairment or combination of mental and physical impairments; that are likely to continue indefinitely; result in substantial functional limitations; and is manifested before the person turns age 22. It cannot be a mental illness condition.

i) Intellectual disability or mental retardation verified in a psychological examination administered by a psychologist licensed in Wyoming, with substantial functional limitations verified by the psychologist in three or more of major life activity areas. NOTE: "Mental Retardation" is a term that has been replaced in Wyoming statute and is currently considered an "intellectual disability" as defined and characterized in the DSM-V manual.

ii) Developmental disability due to a related condition as determined by a physician or psychologist licensed in Wyoming with verification in a psychological evaluation that the person has

significant functional limitations in three or more of major life activity areas. "Developmental disability" means a severe, chronic disability of a person which:

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

b. Is likely to continue indefinitely;

c. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency;

d. Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or

e. Is manifested before the person turns age 22

6. Qualifies on the Inventory for Client and Agency Planning (ICAP) assessment with one of the following:

i) A service score of 70 or less (if ages 18 and older);

ii) An adaptive behavior quotient of .50 or below (for ages 0 through 5);

iii) An adaptive behavior quotient of .70 or below (for individuals 6 through 17); or

iv) Significant functional limitations in three (3) or more of the life activity domain areas: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency

7. Has assessed service needs in excess of $30,000 or meets emergency criteria as approved by the ECC or meets one of the Comprehensive Waiver Reserved Capacity slots.

ICAP Assessment

Completing the ICAP

ICAP Assessment

The ***Inventory for Client and Agency Planning*** (ICAP) is an assessment of the person's functioning level. It reviews the adaptive and maladaptive behaviors of the applicant. This process involves gathering information to determine the type and amount of special assistance that the applicant may need. The assessment measures the applicant's motor skills, social and communication skills, personal living skills, and community living skills. It requires input from people who know the applicant, such as friends, family members, teachers, etc.

The Case Manager will use a checklist to assist the applicant in obtaining all the required documentation for this assessment. These documents will become part of the electronic case file after they are scanned by the Case Manager. A contractor with the DD Section, the Wyoming Institute for Disabilities (WIND), will then complete a confidential evaluation. WIND will contact the applicant to complete the ICAP assessment. This assessment is paid for by the DD Section. The ICAP process may take up to 60 days.

Applying for the Waiver – Step 1

Step 1: Contact BHD-DD Section to Apply

An applicant requesting information on waiver services may contact the BHD - DD Section ***Participant Support Specialist (PSS)*** in his/her county to arrange a time to meet in person or by phone to discuss the details of the waiver application process. The table below provides the contact information for each PSS by county. The PSS will schedule an appointment with the applicant to discuss the waiver application process.

Step 1 Waiver Application

BHD Participant Support Staff Contact List for Eligibility

County Assignment	BHD Staff Name	Phone Number
Fremont, Sublette, Teton	Beth Leonhardt	307-856-4648
Uinta, Sweetwater, Lincoln	Bonnie Laird	307-789-0618
Campbell, Crook, Johnson, Sheridan	Dalreen Kessler	307-684-7632
Washakie, Park, Hot Springs, Big Horn	Deb Spence	307-527-4181
Weston, Niobrara, Goshen, Albany, Carbon, Platte	Dennis Yost	307-534-4658
Laramie	Jessica Abbott	307-777-3443
Natrona, Converse	Leslie Emond	307-234-6439
Manager	Tammy Arnold	307-777-3321
Manager	Vacant	307-777-8760

Applying for the Waiver - Step 2

Step 2: Meet with the BHD Participant Support Specialist (PSS)

During the meeting with the Participant Support Specialist (PSS), this guide will be discussed. If meeting by phone, the guide will be e-mailed or mailed prior to the meeting. The following information will be reviewed with the waiver applicant:

Step 2 Waiver Application

1. ***Careful explanation of the application process*** – discuss the information in the Application and Guide. (Note: It may take several months to determine eligibility.)

2. ***Information will be provided regarding service options for community-based or institutional services.***

3. ***List of potential Case Managers*** will be provided with suggestions for interviewing to help waiver applicant begin process to choose a Case Manager.

Applying for the Waiver - Step 3

Step 3: Complete Application and Review Other Forms

During the initial meeting with the PSS, the forms listed below will be discussed. These forms must be completed and submitted to the PSS to begin the waiver application process.

1. **Application form** – must be completed and submitted.
2. **Case Management Selection form** – to be completed by waiver applicant and the chosen Case Manager.
3. **Level of Care form** - Criteria for institutional care at an ICF/ID – must meet Level of Care Eligibility requirements. Form will be completed by the Case Manager.
4. **Inventory for Client and Agency Planning (ICAP) checklist** – will be completed by the Case Manager. This assessment is required to determine eligibility.

Step 3 Waiver Application

***Individuals on the Supports Waiver or on the wait list will already have these steps completed.**

The *Level of Service Need score* will be assigned to you in order to see if you qualify for the Comprehensive Waiver and rank you on the Comprehensive Waiver wait list, if funding or slots for new participants are not available. The score will be listed in your letter if you go on the Supports Waiver wait list. Scores 4 or higher are eligible for the Comprehensive Waiver.

The Division's process for emergency requests require the individual to meet the criteria for the Extraordinary Care Committee in order to be considered for the Comprehensive Waiver.

Choosing a Provider

Interviewing and Selecting a Provider

What does my Case Manager do?

Your Case Manager helps you gain access to services by coordinating needed assessments and evaluations, developing and monitoring the individualized plan of care, monitoring the participant's health and welfare, addressing problems in service provision, and responding to crises. S/he will facilitate the development of your plan of care through team meetings with you actively involved and submit the plan of care to the DD Section for approval. S/he will monitor your budget and follow up on concerns as needed. The Case Manager is responsible for making sure that whatever is written and agreed upon by team members in your plan of care is completed, in other words, s/he makes sure providers are doing what they said they were going to do. A Case Manager must do home visits and provide services to you each month. You must have a Case Manager on your plan of care and is considered a required service to keep waiver services.

What if I want to change case managers or providers?

Your case manager should offer you choice in case manager and providers at least twice a year. The case manager should offer you choice in providers at any time, and your team must follow a transition process if there are provider changes. The Division encourages participants to not change case managers more frequently than twice a year to keep consistency in service coordination. Let your case manager know if you want to review your choices for providers, or search the Division's web-based provider list.

What do I ask potential Providers?

When you contact providers, make sure you ask about their policies, procedures and costs, such as "Can I choose my workers? How do I make a complaint about a worker? What can I do when a person is

not working out?" If you hire a provider agency to provide your support and have a problem that the agency will not solve, your case manager should assist you in dealing with the issues. To review your choice in providers, a searchable provider list is located on the Division's website:

http://www.health.wyo.gov/ddd/ddd/provlist.html.

It is the responsibility of the applicant to set-up interviews for a Case Manager. Following is a list of potential questions that the applicant can ask a Case Manager during an interview to get a better feel for who would be a good fit for the applicant's needs:

1. Do you have any openings on your case load? If so, how quickly can you get started?
2. Would you describe your experience working with persons with disabilities?
3. Are you available to meet with me outside of normal business hours?
4. Communication and confidentiality are important to me, would you provide examples how you would honor both of these concerns?
5. Is your current case load manageable so that you can take on a new participant?
6. Are you committed to helping me access other services that I need while waiting for waiver approval? (i.e. social security application, vocational rehabilitation, HUD housing vouchers, food stamps, etc.)
7. When funding is made available to me, will you continue to provide case management services?

Once a choice for Case Manager has been made, complete the ***Case Management Selection form*** in the back of this guide. The form identifies the Case Manager selected. Both applicant and Case Manager signatures are required. The Case Manager is responsible for mailing or faxing the completed form to the PSS, who will get the targeted case management services approved. The Case manager will then help complete eligibility steps.

Interview Worksheet for a Provider

Date Contacted for Interview	Date of Interview	Name of Provider	Phone Number	Address

My Notes (for reflecting on interviews):

Approval and Denial Decisions

Receiving a Letter Indicating Denial or Waiting List Status

For Denials: If the applicant receives a denial of eligibility letter from the PSS, Wyoming Medicaid Rules state that if the applicant disagrees with this decision, he/she may request an Administrative Hearing. This request must be submitted in writing within thirty days after the date of the denial letter and it must identify the reasons for the request and the issues to be addressed at the hearing. The applicant may have representation from an attorney, relative, friend, or support person at the hearing.

For Approvals: If the applicant is eligible, but funding is not available, the applicant will be placed on a waiting list. This simply means the state has more eligible applicants than funding opportunities. When funding does become available, the applicant will be notified in writing. The Case Manager will continue to assist the applicant in receiving non-waiver services, providing any crisis intervention and stabilization, and linking the applicant to available resources.

Funding Letter

Receiving a Letter Indicating Eligibility for Funding

When a person on the waitlist for the Comprehensive Waiver receives a funding letter from the DD Section Participant Support Manager stating eligibility for waiver services, which includes the applicant's ***Individual Budget Amount*** (IBA). Then the following will take place:

1. The Case Manager will assist you in contacting the Long Term Care Unit to inform them of the receipt of the funding letter, so they can determine financial eligibility.
2. The Case Manager or DD Section's PSS will meet with you to review Choice, the Team Meeting process, Self-Direction, Conflict of Interest, and waiver services.
3. You will work with your case manager and team advocates to determine which waiver services are needed by reviewing services, providers and the service handbooks.
4. The Case Manager will set up a Team Meeting to develop the ***Individualized Plan of Care*** (IPC).
5. The Case Manager will complete the IPC and submit it to the Division for approval, so that services can begin.

Receiving a funding letter

Filing a Complaint or Grievance

Filing a Complaint or Grievance

Complaints may be filed with the Division online, in writing, or verbally and can be filed with any Division staff person. However, unless the complaint involves a waiver participant whose health or safety is in jeopardy, complaints must be in writing.

The Division encourages people with a complaint to work with the provider or party with whom he or she has concerns. If the person is unable to do so, or if the person has filed a formal grievance with the provider and is not satisfied with the results, then the Division treats the concerns as a formal complaint.

The Division will notify the person within ten calendar days that the complaint has been received and the anticipated timeframe for investigating it. If the person with the complaint is not the participant or guardian, the Division cannot share the results of the investigation due to confidentiality. If a participant or guardian has the complaint, then the Division will notify them of the results of the investigation.

If the investigation involves a waiver provider, the provider will receive a written report including the findings, corrective actions, timeframes for completion of corrective actions, and applicable standards.

Team Meetings

Purpose of Team Meetings and Developing the Plan of Care

Why do we have all of these team meetings?

All Waiver participants are required to have an annual plan of care development meeting and six month plan review meeting to discuss the plan and services. The case manager coordinates these meetings. The case manager will ask you prior to the meeting who you want as providers and who you want to attend the meeting. The case manager must give thirty day written notice to all team members when there is a meeting, unless it is a special meeting for another reason.

What can I expect at the team meeting?

This meeting is used to plan how services will be delivered according to your preferences, needs and desires. Chosen providers should be at this meeting and should discuss how they will provide services to you. Your case manager will go over the plan of care with you. Your objectives for habilitation services will also be discussed. You will be informed of your rights and any restrictions you may have. The services, service rates, or cost of services, and your budget information will be discussed.

How can I prepare for this meeting?

You should review the waiver services available and determine which services and providers you want before your meeting. Your case manager should have reviewed a provider list with you. You will select who you want to be your providers. You can complete some plan of care forms with your case manager before the meeting such as the vision, medical information, etc. Look over the plan of care so you know what to expect at the time of the team meeting.

Do not <u>sign</u> forms until the plan is complete.

What do I have to do at the meeting?

Provide input on your needs, desires, likes, dislikes, and answer questions, and tell the team about your preferences. You will be asked to sign various forms for the plan of care to indicate you agree with the plan, services and providers chosen, and the allocation of your budget. Other than the plan of care, *t*he case manager or other providers may have other forms for you to sign such as a release of information, medication consent, etc.

When can my services begin each year or when my plan changes?

After the team meeting, the case manager submits the plan of care, or modification to the plan, to the DD Section for approval and to prior authorize services. DD Section Staff will review your plan of care and work with your case manager for any corrections or other information needed. Once approved, DD Section staff will prior authorize services electronically by approving the plan (*no plan is valid without Division approval on the service authorization form*). The case manager will be notified electronically of the approved plan. Your case manager will route the plan of care and service authorization form to all providers on the plan and make sure they have received training on how to implement your plan. Services can then begin on the appropriate start date! It is the case manager's responsibility to monitor the plan after services begin on a monthly basis. If there are any concerns or questions you have with your plan, you should visit with your case manager and he/she will follow up.

What responsibilities do my providers have?

They shall participate in your team meeting, follow your plan of care as written, provide billing documentation and any other information necessary in timely manner, use the team meeting process if changes to your plan are recommended, follow the Division's transition process for any changes in services, respect you and your rights, and contact the Division if their address changes. ***THEY SHALL NOT PROVIDE SERVICES UNLESS THEY HAVE AN APPROVED COPY OF THE SERVICE AUTHORIZATION FORM.*** As services are provided, they must keep accurate records of units used and send a copy of billing and documentation to your case manager by the tenth day of each month. They shall also keep abreast of current Division updates and trainings.

What are my responsibilities?

Participants, guardians, and parents have responsibilities while receiving waiver services. Some of the main responsibilities include:

- ✓ To assist in developing the plan of care and gathering information
- ✓ To choose providers and services
- ✓ To attend team meetings and cooperate with case manager to provide 30 days' notice to team members
- ✓ To be available for the case manager to have a monthly home visit as required by the Division
- ✓ To be available when your providers come to work with you.
- ✓ Inform your case manager of any changes in services, and follow Division's transition process when changing providers
- ✓ Each year, follow up with DFS financial eligibility requirements
- ✓ Attend Division training sessions whenever possible

For a complete list of responsibilities, you can look at the Division website for the list, or ask your case manager to review these with you.
http://www.health.wyo.gov/ddd

Participant Rights

Participant Rights While Receiving Waiver Services

While receiving waiver services, participants have the right to:

- Be safe and free from abuse, neglect, mistreatment, intimidation, and exploitation.
- Advocate and file a complaint if someone violates my right to safety or violates any of my other rights.
- Receive person-centered planning when my waiver plan of care is being developed so that the supports and services are about me, my goals, my preferences, and my needs.
- Help develop my waiver plan of care.
- Be informed of all of my rights each year when I receive waiver services.
- Be a part of the decision making process regarding my services and supports.
- Speak up and voice my needs, desires, interests, and goals to my team and provider staff.
- Receive services and supports that reflect my needs, desires, interests, and goals.
- Receive ongoing training and support in order to perform as much of my personal care tasks as possible.
- Receive training on new skills and pursue new ideas or activities so I can become more independent and take care of my own needs as much as possible.
- Live in the most independent and inclusive place possible.
- Pursue work, make money, and fully participate in the community when I want.

- Know and understand my treatment program, its development or changes, and the results of examinations, evaluations, and assessments.
- Receive assistance in knowing about, securing, and retaining basic entitlements, community resources, or any other service that I might be eligible for.
- Be informed of any rights restrictions imposed on me, and have them identified in my plan of care.
- Have my plan of care identify how and when my rights will be restored.
- Be notified by my providers of any associated costs to me for services or items and the terms of payment.
- Receive a 30 day notice from my provider if I am asked to leave their services.
- Choose the services, supports, and providers that I receive through the waiver.
- Change my mind about any or all of the services I receive.
- Change providers if I am not satisfied.

Check out our new

Participant Rights Guide

for more information on your rights!

Waiver Roles and Responsibilities

Participant/Guardian Roles and Responsibilities

Participants/guardians are responsible to:

- Assist in providing evidence of the need for services and supports.
- Assist in providing information so the case manager can complete the Level of Care Criteria form.
- Assist in collecting necessary data and documentation, including school records, medical records, and social security information.
- Provide guardianship papers from the court and notify the case manager if there are any changes in guardianship or representative payee.
- Assure that all providers are given necessary medical information, emergency information, contact information, and training.
- Choose among providers and services and to have choices respected.
- Keep informed of waiver changes through the website or educational opportunities provided by the DD Section.
- If self-directing waiver services, follow the requirements and responsibilities for that option.
- Participate in the program planning process, including participating in the development and review of the Individualized Plan of Care (IPC). **This includes coordinating with the case manager to schedule IPC meetings at least 30 days in advance of the meeting date.**
- Each year, submit forms and information to the Long Term Care Unit (LTC) to complete an annual financial eligibility review.
- Learn about rights and restrictions and be an active participant in any discussion about possible rights restrictions.
- Abide by all rules, laws, and expectations of the community.

- Take care of personal property and protect it from theft or loss.
- Ask any questions about direct responsibilities, if information or directions are not understood.
- **Be available (with the participant at home) for the monthly/quarterly home visits** required by the case manager, canceling in an appropriate amount of time so as not to disrupt service.
- Inform the case manager and/or providers of any concerns or questions, and to give them an opportunity to address any concerns or questions.
- Inform case manager of any requested changes in services and follow DD Section transition procedures when changing service providers or moving to another location in the state. This includes scheduling the transition meeting two weeks in advance and allowing one week for the modification to be approved before the services are changed or the move takes place.
- A guardian of a participant, will provide information to the courts at least twice a year or as required by the courts.
- Review and verify documentation of services provided, when needed.
- Review the Individualized Plan of Care and make sure it reflects the services and supports that are required and agreed upon.
- **Notify DD Section PSS and case manager of changes in residence, phone, guardianship, custody, etc.**
- Provide the case manager or providers with information in a timely manner on incidents, medication concerns, behavioral concerns, and other important information.
- Participate in assessments as needed for continued waiver eligibility determination.

Roles and Responsibilities

Case Manager
Roles and Responsibilities

Case Managers are responsible to:

- Coordinate assessment and /or reassessment of the need of waiver services.
- Initiating the process to evaluate and/or re-evaluate the individual's Level of Care Criteria.
- Assist the team in determining which services are priorities.
- Support choices and preferences unless doing so is illegal or clearly not in the best interests of the participant.
- Educate the participant/guardian on self-direction and assist them in understanding the responsibilities of that choice.
- Provide the participant/guardian with informed choice regarding current service providers including other case managers.
- Assist the team in developing the IPC that includes the needs, interests, and goals of the participant.
- Review the plan of care with the participant and team in a manner that is easy to understand.
- Assist the providers/team in developing a personalized schedule for the participant.
- Give copies of the Individualized Plan of Care to providers in accordance with applicable privacy and confidentiality law and regulation.
- Monitor services and billings by providers on the Individualized Plan of Care.
- Be available to and at the times and places that are convenient for the participant and provide emergency contact information.

Case Manager Roles & Responsibilities

- Complete a home visit each month/quarter if not in a residential service, which is required to bill for case management services. The participant must be in the home at the time of the visit.
- Provide the minimum amount of case management services in the categories of: home visit plan development, monitoring and follow-up, participant specific training, face to face meeting with participants, guardian, family, advocacy and referral, crisis intervention, coordination of natural supports, and team meetings.
- Observe services in various setting to verify if the plan is being implemented, if schedules are accurate, if objectives are being implemented and progress is being made, and if the participant's desires are being met on a quarterly basis.
- Provide education on self-direction opportunities within the waivers.
- If a participant is self-directing, work with the support broker and employer (the participant/family) to complete case management duties as listed in the service definition.
- Provide second line monitoring of medication regimes as outlined in the IPC.
- Monitoring the use of restrictions and restraints as outlined in Positive Behavior Support Plans and completing trend analysis.
- Provide DD Section and other agencies or providers with information in a timely manner on incidents, medication concerns, behavioral concerns & other important information.
- Responsible for knowing and sharing current participant specific information; i.e. change in medications, behavioral changes, etc.
- Responsible for knowing current DD Section updates and training.
- Provide 30 days' notice for team meetings – semi-annually and annually.
- Submit IPC to DD Section PSS 30 days prior to the Individualized Plan of Care start date.

Roles and Responsibilities

Provider Roles and Responsibilities

Providers are responsible to:

- Participate in team meetings and provide pertinent information that allows the team to make the right decisions about services and supports.
- Follow the Individualized Plan of Care (IPC) and notify the case manager when there are questions or concerns with the plan.
- Provide the participant/guardian and the case manager with information in a timely manner on incidents, medication concerns, behavioral concerns, billing documentation, and other important information.
- Use the team process to determine if changes need to be made to services on the Individualized Plan of Care, including changes to medications, behavior plans, meal time plans or any other significant changes that impact the services on the IPC.
- Follow DD Section transition procedure to facilitate transitions prior to accepting participants into services or agreeing to serve them.
- Responsible for knowing current DD Section updates and training.
- Respect the participant's rights and cultural differences and assure that all staff understand and respect the rights of the participant.
- Follow Medication Assistance guidelines if in the Individualized Plan of Care.
- Provide documentation of internal and critical incidents to the case manager.

- Provide documentation of restraints and/or restrictions if identified in a Positive Behavior Support Plan.
- Notify DD Section PSS of any changes in address, phone or email immediately to alleviate any chance of deactivation or disruption of payment.
- Do not provide services until a copy of the Individualized Plan of Care, which includes the service verification form, and all appropriate signatures, is received.
- A copy of monthly documentation must be sent to the appropriate case manager by the 10th business day of the calendar month.
- Keep accurate records of units, including the number of units used in the IPC, and notify the case manager if unit usage is changing.
- Responsible for developing schedule and objectives with team input.
- Providers need to be available for Case Managers and Participant Support Specialist to observe trainings and services.
- Allow Case Managers and DD Section staff to monitor waiver services.

Service Delivery Options

Types of Services Delivery

Wyoming offers two options for service delivery, which can be explained by your case manager in more detail:

1. **Traditional service delivery**, in which the provider you choose determines the staff who will be hired or assigned to work with you, where staff will work, how much they will be paid, and how the services will be delivered overall.

2. **Self-Directed service delivery**, in which you and/or your guardian have more choice and control over the kinds of services received, how they are delivered, and by whom. Through self-direction, waiver participants can become the employer of their staff, can manage their own budgets, and can purchase goods and services if using the Fiscal Employer Agent to self-direct. Participants also have flexibility and authority in setting wages for services within ranges.

Can I do both?

Yes. You may choose to self-direct some of your waiver services and keep some services through traditional provider agencies.

What does a Traditional Provider do?

Instead of hiring workers directly, you can contract with a waiver provider agency to manage your support, which is the traditional way services have been delivered. Many provider agencies offer a variety of supports, ranging from personal care and habilitation services to job coaching or supported living and homemaking services. The main advantage of hiring through a provider agency is that the agency is responsible for sending a worker, and when needed, a back-up worker to you if your regular worker is unavailable. When you hire an agency to provide workers, the agency as the employer has the responsibility of hiring, training and managing workers, and handling all of the employer duties. This arrangement means that you do not have to deal with the paperwork and details of hiring and employing a worker.

This also means that you may not have a choice of who your workers are, and you may not be able to discipline or fire your workers directly; the agency will do this. You should, however, have the option of using different workers if the worker they send does not meet your needs. Hiring a provider agency to get workers will likely be more costly in your waiver budget than hiring your worker directly and the worker may be paid less per hour. Some of the cost goes toward administrative fees including worker's compensation, health and liability insurance, and possibly other benefits for your workers.

Self-Directing Services

Steps to Self Direction

What Is Self-Direction?

Self-direction allows a waiver participant or legal representative to decide which services would best meet your needs, encourages you to design your own plan of care, manage your own budget, decide who to hire to provide support for you, and negotiate the wages you want to pay to your employees. Self-Direction is a process for delivering services that gives persons who need care more choices and control over the kinds of services they receive, how they are delivered, and by whom. These services are combined with natural supports and are planned around personal goals and preferences. Self-directed services differ from the traditional provider-driven service delivery process in which providers determine who will be hired, where staff will work, how much they will be paid, and how the services will be delivered overall.

What are the benefits to self-directing?

When self-directing, you employ your own workers for you or your child on the waiver. You have more control and authority over your budget. A worker hired through self-direction may help in your home, accessing community services and supports, employment, laundry, grocery shopping, providing personal care or money management. When you need help or don't understand something, contact your support broker or case manager, who will provide assistance and support along the way. You also will have a financial management service to handle many of the employer functions for you, such as tax and legal requirements. With the support of these people who care about you, you can do it!

Recognizing and Reporting Abuse/Neglect/Exploitation

Recognizing and Reporting

All citizens have a responsibility to protect those who cannot protect themselves. **Wyoming state law (W.S. 14-3-205 & 35-20-103) mandates that any person who suspects child/vulnerable adult abuse, neglect or exploitation is required to report.**

According to Wyoming law, everyone must report suspected abuse, neglect or exploitation of a child or vulnerable adult if they have reasonable cause to believe that it may be occurring.

As abuse/neglect/exploitation has no boundaries according to sexual orientation, ethnic background, age, religion, disability, or gender, the reporting of abuse/neglect/exploitation of children and vulnerable adults is a 24-hour obligation.

Help us spread the word about the importance of reporting abuse or neglect and remind all citizens that reporting is the first step toward protecting a child or vulnerable adult who might be in danger.

Reporting Abuse, Neglect, or Exploitation

To learn more about mandatory reporting and help protect Wyoming's vulnerable population visit the Wyoming Victim Services website at http://victimservices.wyoming.gov/.

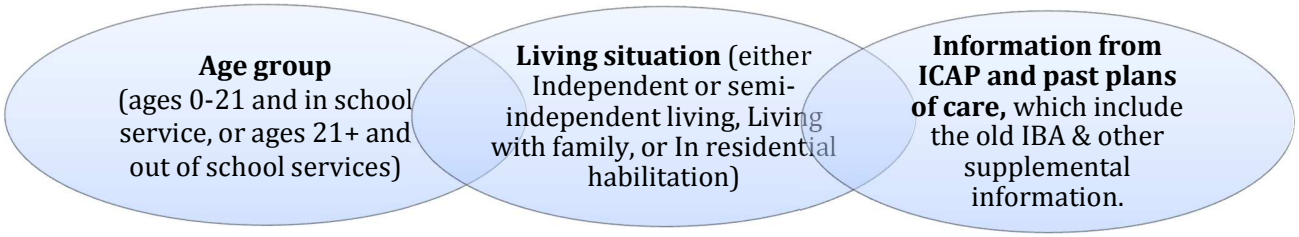
Comprehensive Waiver IBA Methodology

Individual Budget Amount (IBA)

The new IBA method

The Division uses three (3) factors to determine a participant's Individual Budget Amount (IBA): the person's age group, living situation, *Inventory for Client and Agency Planning* (ICAP) assessment, and prior plans of care and service utilization. The figure below shows the interaction between these factors. Different living situations require different levels of funding. Participants with more assessed needs and residential services require more funding than participants living at home or living independently. *The Level of Service Need Scoring Rubric (located on the next page),* includes descriptions of the assessed *Level of Service Need.*

Budget Development Factors



Four (4) steps determine the assessed *Level of Service Need score*:

The first step converts data on service needs from the ICAP assessment subscores into a continuous scale from 1-6. A continuous scale means that scores may have fractions, such as 2.4 or 4.5. Independent and high functioning individuals are rated between 1-3. People with higher needs are rated between 4-6. All participants receive an initial *Level of Service Need* score.

The second step converts subscores from the ICAP's *Behavioral* and *Medical domains* into a 1-6 scale.
This step will affect the *Assessed Level of Service Need* for some participants because the higher score of the two passes is kept.

The third step flags individuals with high-assessed medical and behavior service needs, as indicated by the ICAP. This pass increases their final *Assessed Level of Service Need.* This step only affects participants with severe medical and behavioral needs. This step finalizes the *Level of Service Need Score,* which equates to a preliminary budget amount.

The fourth step caps any IBA change for transitioning participants at ±7% before finalizing the budgets. Existing waiver participants going to the Comprehensive Waiver are limited to change of ±7% of old budget.

Final Score and IBA

The overall Level of Service Need score assigned is a result of the three (3) steps. The preliminary budget is assigned based on a budget amount associated to the final score. Then, the former IBA is compared against the new preliminary budget.

The new "final" IBA is either more or less than the former IBA but is limited an increase or decrease of 7%.

New people *funded onto the waiver from the wait list will not be impacted by the 7% cap. They will get a budget that corresponds with the level of service need score assigned.*

The 7% cap complicates the model, but minimizes the impact to any one participant.

If two people with the same score had different budgets on the Adult DD waiver, the new IBAs with the 7% cap will still show two different IBAs for the same score.

Level of Service Need Scoring Rubric

Level 1: The person requires few supports weekly due to a high level of independence and functioning compared to one's peers. This person is independent with Activities of Daily Living (ADLs) but may follow checklists as reminders. No significant behavioral or medical issues that cannot be controlled with medication and routine medical care. Person requires minimal support services that can be provided within a few hours per week, and can be left alone in the home or community for extended periods of time.

Level 2: The person requires infrequent care and limited supports daily due to a moderately high level of independence and functioning. Some days may not require any support. Behavioral needs, if any, can be met with medication or informal or infrequent verbal redirection by caregivers, which may or may not require a PBSP. There may be a need for day services and intermittent residential support services to assist with certain tasks, and the person can be unsupervised for several hours at time during the day and night.

Level 3: The person requires limited personal care and/or regular supervision due to a moderate level of functional limitations in activities of daily living, requiring staff presence and some physical assistance. Behavioral needs, if any, are met through medication, informal direction by caregivers, and/or occasional therapy (every one to two weeks). Person does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day. Intermittent personal attention should be given daily for training, personal care, community or social activities.

Level 4: This person requires regular personal care and/or close supervision due to significant functional limitations, medical and/or behavioral conditions. Therapy and medical care may be needed monthly in addition to support from staff. Behavioral and medical supports are not generally staff-intensive and may be provided in a shared staffing setting. Regular attention is needed throughout the day for training, personal care, reinforcement, community or social activities.

Level 5: The person requires extensive personal care and/or constant supervision due to behavioral or medical concerns or due to significant functional limitations concerns, including frequent and regular on-site staff interaction and support. Therapy and medical care may be needed bi-monthly in addition to support from staff. Behavioral and medical concerns must be addressed with written behavioral and/or medical plans and protocols. Support needs are highly intense, but can still generally be provided in a shared staff setting. Staff must provide line of sight supervision and frequent personal attention must be given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

Level 6: The person needs total personal care and/or intense supervision throughout the day and night. Supervision by at one staff on-site/in residence (not shared) must be conducted by at least line of sight, with much of the staff's time within close proximity providing direct support during all waking hours. At times, the person may require the full attention of two staff for certain activities of daily living and in response to certain behavioral events. Therapy and medical care may be needed weekly in addition to support from staff. Typically, this level of service is only needed by someone with intense behaviors, not just medical needs alone. There is no ratio flexibility from the amount approved by BHD in the plan of care. Behavioral and medical supports require written plans or protocols to address support needs.

Questions on IBA or Level of Service Need Score?

If a participant or guardian believes the assigned Level of Service Need score or living situation is incorrectly represented in the IBA letter sent, they should contact their case manager who will get in touch with the Division. And as always, participants and guardians may contact the Division if they have questions or do not understand the process.

Waiver Service Descriptions

ADULT DAY SERVICES (ages 21+ only)	Adult Day Services are structured services consisting of meaningful day activities that maximize or maintain skills and abilities, keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, maintain, personal skills; introduce new leisure pursuits, establish new relationships, improve or maintain flexibility, mobility, and strength; or build on previously learned skills. Services also include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by unlicensed direct support professionals identified in the plan of care. They are usually provided in a congregate setting. When provided in congregate community setting, there must be staff on-site within immediate proximity to allow staff to provide support and supervision, safety and security, and provide activities to keep the person engaged in their environment. Transportation into the community to shop, attend recreational and civic events, or other community activities and resources, is a component of Adult Day Services and is included in the rate to providers.
BEHAVIORAL SUPPORT SERVICES	Behavioral Support Service includes training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors through the implementation of positive behavior support and interventions. Behavioral Support service can also be accessed for the intent purpose of reducing the use of restrictions and restraints within a participant's current plan of care or service environment.
CASE MANAGEMENT	Case management is a service to assist participants in gaining access to needed waiver services, Medicaid State Plan services, medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for assessment and/or reassessment of the need for waiver services; initiating the process to evaluate and/or re-evaluate the individual's level of care; linking waiver participants to other Federal, state and local programs; developing the plan of care according to state policies and procedures; coordinating multiple services and/or among multiple providers; ongoing monitoring of the implementation of the plans of care; ongoing monitoring of participant's health and welfare; addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare; responding to participant crises; reviewing service utilization and documentation of all services provided on a monthly basis to assure the amount, frequency, and duration of services are appropriate.
CHILD HABILITATION (ages 0-17 only)	Child Habilitation Services provide children with regularly scheduled activities (and/or supervision) for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management.
COGNITIVE RETRAINING	Training provided to the person served or family members that will assist the compensation or restoring cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the Plan of Care (POC).
COMMUNITY INTEGRATION SERVICES (ages 21+ only)	Community Integration Services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Services should be furnished in any of a variety of settings in the community and are not limited to fixed-site facilities. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision. 50% percent of the time in service must be planning and participating in community integrated activities.
COMPANION SERVICES (must be 18 or older)	Companion services include non-medical care, supervision, socialization and assisting a waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion Services include informal training goals in areas specified in the individual plan of care.

CRISIS INTERVENTION SUPPORT	Crisis Intervention services may be added to a plan for situations where a participant's tier level may not provide sufficient support for specific activities, medical conditions or occurrences of behaviors or crisis, but the extensive supervision is not needed at all times. The service may only be provided to a participant age 18 years or older in habilitative residential or day services. Crisis Intervention provides funding for extra support from another staff to supervise a participant in the habilitation service during times of periodic behavioral episodes where the person is a danger to oneself or others, or if the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and non-violent, non-physical crisis intervention services to de-escalate a situation, teach appropriate behaviors and keep the participant safe until the participant is stable.
DIETITIAN SERVICES	Services furnished by a licensed Dietician, including menu planning, consultation with and training of caregivers, and education of participants.
EMPLOYMENT DISCOVERY AND CUSTOMIZATION	Employment Discovery and Customization is the individualized determination of the strengths, needs, and interests of the participant and is designed to meet the specific needs of the employee and employer relationship. Employment discovery and customization includes employment developed through job carving, self-employment or entrepreneurial initiative, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants. Employment discovery and customization presumes the provision of reasonable accommodations and supports necessary to perform functions of a job that is individually negotiated and developed. The first 100 units may be used to complete the Employment plan, 300 for job development. There is a 400 unit's service limit on either waiver.
ENVIRONMENTAL MODIFICATIONS	Environmental modifications include those functionally necessary physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. There is a lifetime cap of $20,000 per family, regardless of waiver.
HOMEMAKER	Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others in the home. There is no cap on the Supports Waiver. On the comprehensive waiver the cap is 624 units per year – a maximum of 3 hours per week.
INDEPENDENT SUPPORT BROKER (For Self-Directing)	Independent Support Brokerage is a service that assists the participant (or the participant's legal representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or legal representative, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. The Support Broker offers practical skills training to participants and their legal representatives to enable them to independently direct and manage waiver services. Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. There is annual cap of 320 units for both the Comprehensive and Supports Waivers. IBAs will not be increased to add this service.
INDIVIDUAL HABILITATION TRAINING	Individual Habilitation Training (formerly Residential Habilitation Training) is a specialized 1:1 intensive training service to assist a participant with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are for participants who live with unpaid caregivers or who need less than 24-hour paid supervision and support. Individual Habilitation Training services have a four (4) hour a day limit and units shall be approved based upon the participant's need and budget limit.
OCCUPATIONAL THERAPY (ages 21+ only)	Services furnished by or under the scope of practice of an occupational therapist and necessary to keep a participant in his or her home or out of an institution.

PERSONAL CARE	Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. Personal Care services may include the preparation of meals, exclusive of the cost of the meals. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the participant, rather than the participant's family. The participant must be in the home when the service is being provided. Personal care can include Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IADLS). • **ADLS** include bathing, dressing, toileting, transferring, positioning, maintaining continence, other hygiene tasks, eating, etc. • **IADLS** include more complex life activities, such as personal hygiene, light housework, laundry, meal preparation, exclusive of cost of meal, using the telephone medication and money management.
PHYSICAL THERAPY (ages 21+ only)	Maintenance or restorative services provided by or under the scope of a licensed physical therapist, which are necessary to keep a participant in his or her home or out of an institution.
PREVOCATIONAL (ages 18+)	Prevocational services are services designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.
RESIDENTIAL HABILITATION	Residential Habilitation services are individually-tailored supports for a waiver participant that assists with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation includes personal care, protective oversight and supervision. Residential Habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of ongoing 24 hour support by a provider on site. Services can be furnished in a group home, shared living arrangement, host home, or in the participant's home. Residential Habilitation may be furnished in a home owned or leased by a provider or the participant. **New participants not yet in a Residential service must meet the targeting criteria in order to receive this service.**
RES HAB SHARED LIVING	**For Residential Habilitation delivered through self-direction as Shared Living** This service may be self-directed for an individual in a shared living setting, where the participant or participants own or lease the residence from an entity that is not a certified waiver provider. The employee hired through self-direction may serve up to 3 people in shared living, but can serve no other people in a residential habilitation service. This service is based on a tiered level of service.
RESPITE	Respite consists of services provided to participants unable to care for themselves. Respite is intended to be utilized on a short-term basis because of the absence or need for relief of the natural caregiver. Respite must be episodic, for special events when the caregiver needs relief. Respite cannot be used as a substitute for care while the primary caregiver is at work. It cannot be used for daily scheduled supervision. The amount of Respite services authorized shall be based upon need and does not include similar services otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children. There is an annual cap on the Comprehensive waiver.

SELF-DIRECTED GOODS & SERVICES (Only available for those Self-Directing)	Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care. Participant must Self-Direct at least one direct service through the Fiscal Employer Agent to utilize goods and services. Equipment purchases have a cap of $2,000 and cannot include any item covered under the specialized equipment waiver service. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for an equipment purchase by a Certified Specialized Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap. Electronic technology devices are only allowed once every five (5) years and like items cannot be purchased during those five (5) years. There are no exceptions. The Division shall limit the purchase of any general item purchase and only allow the purchase of an iPad or other electronic devices, if recommended by CSE professional.
SKILLED NURSING	Skilled Nursing services are medical care services delivered to individuals with complex chronic and/or acute medical conditions, which is performed within the Nurses' scope of practice as defined by Wyoming's Nurse Practice Act, which includes the application of the nursing process including assessment, diagnosis, planning, intervention and evaluation and the administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the execution of the medical regimen. The services must require a level of expertise that is undeliverable by non-medical trained individuals.
SPECIAL FAMILY HABILITATION HOME	Special Family Habilitation Home consists of participant specific, individually designed and coordinated training within a family (other than biological or adoptive parents) host home environment. **This service is only available to children who are already receiving this service in an approved plan of care. The service is not open to newly enrolled participants.** This service is intended for children birth through 20 years of age. The provider is the primary caregiver and assumes 24-hour care of the individual. The provision of special family habilitation home services includes personal care needs, so plans of care are not approved that include both residential services and personal care services. Providers are responsible for both formal and informal training opportunities. The schedule must be individualized and the training objective must be meaningful.
SPECIALIZED EQUIPMENT AND SUPPLIES (New & Repair)	Services include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Items reimbursed with waiver funds shall exclude any medical equipment and supplies furnished under the Medicaid State Plan. There is an annual cap of $2,000 per year.
SPEECH, LANGUAGE, & HEARING SERVICES (ages 21+ only)	Speech Therapy services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy. Speech Therapy services through the waiver can be used for maintenance and the prevention of regression skills. The units must be prior authorized and must be prescribed by a physician.
SUPPORTED LIVING SERVICES (ages 18+)	Supported Living services assist a participant to live in a home or apartment leased by the participant or guardian, or in the family home when the participant requires a range of community-based support to live as independently as possible. These individuals do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence. They require individually-tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community. Supported living services shall be based upon need. These services can include: assisting with common daily living activities; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; teaching the use of the community's transportation system; teaching the use of police, fire and emergency assistance; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life; and 24-hour emergency assistance.

SUPPORTED EMPLOYMENT (ages 18+)	This waiver offers various employment support services to support and assist a participant (ages 18+) who, because of their disability, needs intensive support to find and maintain a job in competitive, integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability. The outcome of using the employment pathway of support services is to help a participant find and maintain a job that meets personal and career goals. A range of supported employment services are available with varying levels of support and intensity to assist the participant in attaining and maintaining the highest level of paid, community integrated employment. Supported Employment Services may be provided in an individual setting or in a group setting.
SUPPORTED EMPLOYMENT FOLLOW ALONG	Services and supports that enable a participant who is paid at or above the federal minimum wage to maintain employment in an integrated community employment setting. Service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. SEFA may cover support through phone calls between support staff and the participant's managerial staff.
TRANSPORTATION	Transportation service on the waiver is a gap service to enable participants to gain access to an employment location, community services, activities, and resources as specified by the plan of care when a service provider is not needed at the event. Service is not intended to replace formal or informal transportation options, like the use of natural supports, city transportation services, and travel vouchers. Transportation services under the waiver shall be offered in accordance with an individual's plan of care and whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or with other resources will be utilized.

Please refer to the Services Definitions located on the DD website for further information on each service: http://health.wyo.gov/ddd/index.html

Waiver is Payer of Last Resort

By federal law (42 CFR §433 Subpart D, §433.138, and 433.139), third parties who are liable for payment of services must be identified. The Medicaid waiver is considered a payer of last resort. If another insurer or program has the responsibility to pay for costs incurred by a Medicaid eligible individual, that entity is generally required to pay all or part of the cost prior to the Medicaid Waiver making any payment. Some of these services listed may be available through the Rehabilitation Act of 1973 (Department of Workforce Services or Division of Vocational Rehabilitation (DVR), Public Law 94-142 (Department of Education), Medicaid, Medicare, state and federal grants, private insurers, or other available programs. If the service is available to the participant, it must be accessed prior to requesting and using waiver funding.

Definitions

Definitions for Commonly Used Terms in Waiver Programs

Below are definitions for commonly used terms in the waivers.

Advocate: A person, chosen by the participant or legal guardian, who supports and represents the rights and interests of the participant in order to ensure the participant's full legal rights and access to services. The advocate can be a friend, a relative, or any other interested person. An advocate has no legal authority to make decisions on behalf of a participant.

Adult: A person who is twenty-one years of age or older for purposes of the Adult Developmental Disabilities Home and Community Based Waiver.

Acquired Brain Injury (ABI):

I. Any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed, at the brain stem level and above.

II. These dysfunctions are acquired through the interaction of any external forces and the body, oxygen deprivation, infection, toxicity, surgery, and vascular disorders not associated with aging.

III. It is an injury to the brain that has occurred since birth.

IV. It may have been caused by an external physical force or by a metabolic disorder(s).

V. It includes traumatic brain injuries such as open or closed head injuries and non-traumatic brain injuries such as those caused by strokes, tumors, infectious disease, hypoxic injuries, metabolic disorders, and toxic products taken into the body through inhalation or ingestion.

VI. It does not include brain injuries that are congenital or brain injuries induced by birth trauma.

VII. These dysfunctions are not developmental or degenerative.

Case Manager: A service provider who helps an eligible person on the waiver to identify, select, obtain, coordinate and use both paid services and natural supports which enhance independence, productivity, and integration consistent with his or her capacity and preferences.

Child: A person under 21 years of age for participants receiving services on the Children's Developmental Disabilities Home and Community Based Waiver. Participants between the ages of 18 and 21 receive services on the Children's Developmental Disabilities Home and Community Based Waiver but are considered an adult in the State of Wyoming and shall sign their own documents unless they have a legal guardian.

Circle of Support: Specific persons an individual can contact for help or is a natural support. These may include family members, friends, neighbors, advocate, providers, landlord, community members or agencies, or local emergency agencies.

Conflict of Interest: Specific to the Individualized Plan of Care (IPC), a conflict of interest is a situation in which a case manager has competing or conflicting interests or loyalties. Examples include: 1) a self-employed case manager also provides other services on that participant's plan of care 2) an organization employs a participant's case manager and also provides other services on the participant's IPC.

Department of Family Services (DFS): Pursuant to W.S. § 35-20-115, The Central Registry of the Department of Family Services that includes substantiated reports of abuse, neglect, exploitation, or abandonment of vulnerable adults and children.

Developmental Disability: As defined in federal law (42 U.S.C. § 15002 (8)), a severe, chronic disability of an individual that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments.
- Is manifested before the individual attains age 22.
- Is likely to continue indefinitely; and

- Results in substantial functional limitations in 3 or more of the areas of major life activity: Self-care, Receptive and expressive language, Learning, Mobility, Self-direction, Capacity for independent living, and Economic self-sufficiency.
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care treatment or other services, which are of a lifelong ore extended duration and are individually planned and coordinated.

Electronic Medicaid Waiver System (EMWS): Electronic system for managing waivers and case files.

Functionally necessary: A waiver service that is:

I. Required due to the diagnosis or condition of the participant, and
II. Recognized as a prevailing standard or current practice among the provider's peer group, or
III. Intended to make a reasonable accommodation for functional limitations of a participant, to increase a participant's independence, or both.
IV. Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.
V. For the purposes stated, utilization is not experimental or investigational and is generally accepted by the medical community.

Guardian: A person lawfully appointed as guardian to act on the behalf of the participant or applicant.

ICF/ID: This is the Level of Care Criteria for Intermediate Care Facility for persons with Intellectual Disability as defined in 42 U.S.C. § 1396d (d).

Individual Budget Amount (IBA): Allocation of Medicaid waiver funds assigned to a participant to budget services according to one's assessed needs.

Individualized Plan of Care (IPC): A written Plan of Care for a participant that describes the type and frequency of services to be provided to the participant regardless of the funding source and that identifies the provider or provider types that furnish the described services.

Individualized Plan of Care (IPC) team: A group of persons who are knowledgeable about the person and are qualified, collectively, to assist in developing an

individual Plan of Care for that person. Membership of the team shall include the participant, the guardian if applicable, the case manager, providers on the person's individual plan of care, an advocate if applicable, and any other person chosen by the participant.

Intellectual Disability: A term used when a person has certain limitations in mental functioning and in skills such as communicating, taking care of him or herself, and social skills. These limitations will cause a person to learn and develop more slowly than a typical person of a similar age. A person with an intellectual disability may take longer to learn to speak, walk, and take care of their personal needs such as dressing or eating, and are likely to have trouble learning in school. They will learn, but it will take them longer. There may be some things they cannot learn. Intellectual disability is the currently preferred term for the disability historically referred to as "mental retardation." The term intellectual disability covers the same population of individuals who were diagnosed previously with mental retardation in number, kind, level, type, and duration of the disability and the need of people with this disability for individualized services and supports.

Inventory for Client and Agency Planning (ICAP): An instrument used by the DD Section to help determine eligibility and to determine the needs of the participant, available from Riverside Publishing, its successor, or designee.

Medicaid: Provides medical assistance and services pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress and/or the Wyoming Legislature. Medicaid in Wyoming is a program under the Office of Healthcare Financing within the Wyoming Department of Health.

Medical Records: All documents, in whatever form, in the possession of or subject to the control of a provider, which describe the participant's diagnosis, condition, or treatment, including, but not limited to, the Individualized Plan of Care.

Objectives: A specific, measureable, attainable, relevant, time specific and trackable condition or skill that must be attained in order to accomplish a particular goal.

Participant: An individual who has been determined eligible for covered services on the Comprehensive Waiver, Supports Waiver, Child DD Waiver, or the Acquired Brain Injury Waiver.

Person-Centered Planning: A process, directed by a participant, that identifies the participant's strengths, capacities, preferences, needs, the services needed to meet the needs, and providers available to provide services. Person-centered planning allows a participant to exercise choice and control over the process of developing and implementing the Individualized Plan of Care.

Provider: A person or entity that is certified by DD Section to furnish covered services and is currently enrolled as a Medicaid waiver provider.

Psychological Evaluation: A process that evaluates the mental capabilities of a person used to determine eligibility.

Related Condition: A condition that results in a severe, chronic developmental disability affecting an individual which manifests before he or she reaches age twenty-two and that is attributable to cerebral palsy, seizure disorder, or any condition other than mental illness that is closely related to an intellectual disability and that requires similar services, as determined by a licensed psychologist or physician.

Representative Payee: A person or organization appointed by the Social Security Administration to manage Social Security, Veterans' Administration, Railroad Retirement, Welfare Assistance, or other state or federal benefits or entitlement program payments on behalf of an individual who cannot manage or direct the management of his/her own money.

Self-Direction: Is a belief that emphasizes the ability of people with developmental disabilities and, where appropriate, their families, to decide about their own needs and make choices about what services would best meet those needs. The participant design his/her own Plan of Care, designs and manages his/her own budget, and decides whom to hire to provide the support he/she chooses.

Targeted Case Management (TCM): This is a service that allows case managers to get paid for their time spent working with a new applicant or eligible applicant on the waiting list. During TCM services, a case manager can assist the applicant in the following:

- Obtaining the necessary documentation, such as medical records and psychological and neuropsychological assessments to determine eligibility
- Assisting in making initial appointments for applicants with service providers and informing applicants of services available while waiting for funding
- Ensure a participant is following a prescribed service plan and monitoring the progress and impact of that plan
- Being an advocate for applicants for the purpose of accessing needed services
- Providing crisis intervention and stabilization in situations requiring immediate attention/resolution

The Case Manager may not provide any direct service to the applicant, such as driving to appointments.

Traditional Services: This is a provider-driven service delivery process in which providers determine who will be hired, where staff will work, how much they will be paid, and how the services will be delivered overall.

Waiting List: A list of persons who are eligible for covered services and who have submitted a completed application, but the services are unavailable because of limits imposed by funding for or on the waiver.

Helpful Resources

Resources

Brain Injury Association of Wyoming
111 West 2nd Street, Suite 106
Casper, WY 82601
Phone: (800) 643-6457
Website: www.biausa.org/Wyoming

Department of Family Services (DFS)
Local phone numbers listed by county
Website: http://dfsweb.state.wy.us

Department of Health, Aging Division
6101 Yellowstone Road; Suite 186A
Cheyenne, WY 82002
Phone: (307) 777-7986
Website: http://wdh.state.wy.us

Department of Health
Behavioral Health Division
Mental Health and Substance Abuse
6101 Yellowstone Road; Suite 220
Cheyenne, WY 82002
Phone: (800) 535-4006 or
(307) 777-6494
Website: http://wdh.state.wy.us

Department of Health
Behavioral Health Division
Developmental Disabilities Section
6101 Yellowstone Road; Suite 220
Cheyenne, WY 82002
Phone: (800) 510-0280 or
(307) 777-7115
Website: www.health.wyo.gov/ddd

Division of Vocational Rehabilitation (DVR)
1510 E Pershing Blvd
Cheyenne, WY 82002
Phone: (307) 777-7364
Website: www.wyomingworkforce.org

Early Childhood and Intervention
Phone: (800) 510-0280 or
(307) 777-7115
Website:
www.health.wyo.gov/ddd/earlychildhood

Wyoming Governor's Council on Developmental Disabilities
Phone: (800) 438-5191 or
(307) 777-7230
Website: http://ddcouncil.state.wy.us

Parent Information Center
500 W Lott St, Suite A
Buffalo, WY 82834
Phone: (800) 660-9742
Website: www.wpic.org

People First of Wyoming
Phone: (877) 289-7168 or
(307) 432-4033
Website:
www.peoplefirstofwyoming.com

Protection and Advocacy (P&A) Systems
Phone: (307) 632-3496
Website: www.wypanda.com

Shoshone & Arapahoe Social Service
109 Norkok
Ft Washakie, WY 82514

Social Security Administration (SSA)
3001 E Pershing Blvd Ste 140
Cheyenne, WY 82001
Phone: (800) 772-1213 or
(307) 772-2135
Web site: www.ssa.gov

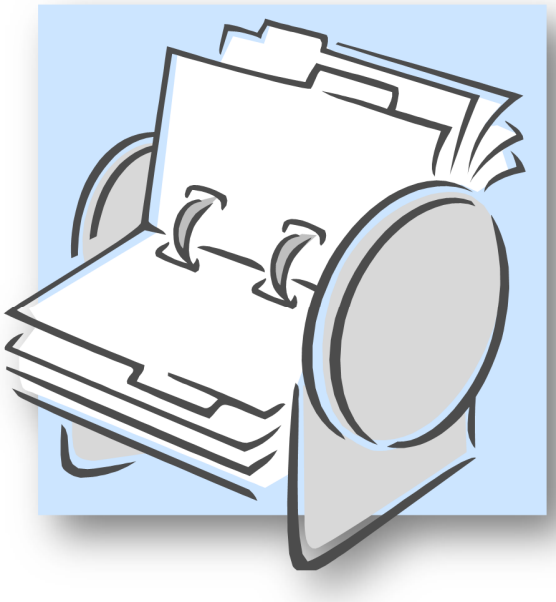
The Arc of Wyoming Chapter (Arc)
Laramie County: (307) 632-1209
Natrona County: (307) 577-4913
Uinta/Lincoln County: (307) 789-7679
Sheridan County: (307) 672-8665
Lander/Riverton: (307) 335-8801

UPLIFT
4007 Greenway Street, Suite 201
Cheyenne, WY 82001
Phone: (888) -875-4383
Website: www.upliftwy.org

Veterans Affairs Commission
5905 CY Avenue
Casper, WY 82604
Phone: (800) 833-5987 or (307) 265-7372
Website: www.va.gov

Visually Impaired Program (VIP)
Local phone numbers listed by county
Website: www.wilr.org/roster.html

WIND Assistive Technology Resources (WATR)
University of Wyoming
Phone: (800) 861-4312 or (307) 766-2764
Website: www.icdri.org/legal/WyomingATP.htm



Wyoming Guardianship Corporation (WGC)
Phone: (307) 635-8422
Website: www.wyomingguardianship.org

Wyoming Independent Living Rehabilitation (WILR)
305 West 1st Street
Casper, WY 82601
Phone: (800) 735-8322 or
(307) 266-6956 Casper
Website: www.wilr.org

Wyoming Institute for Disabilities (WIND)
1000 E University Ave, Dept. 4298
Laramie, WY 82071
Phone: (888) 989-9463 or
(307) 766-2761
Website: www.uwyo.edu/wind

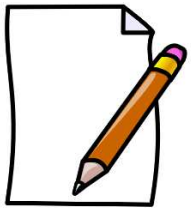
Wyoming Services for Independent Living (WSIL)
190 Custer Street| Lander, WY 82520
1616 E 11th Street| Cheyenne, WY 82009
Cheyenne: (307) 637-5127
Lander: (800) 266-3061 or 307-332-4889
Website: www.wysil.org

Waiver Applicant Checklist

	Task	Date Completed
1	***Contacted*** *Behavioral Health Division - DD Section Participant Support Specialist (PSS)*	
2	***Appointment set with PSS to discuss the Application Process.*** Date_____ Time_____ Location_____ ❑ In Person ❑ By Phone	
3	Received from PSS the ***Application Guide for the Supports Waiver (not the Comprehensive)***	
4	Completed the ***Application form.*** (Mailed form to PSS if meeting by phone; otherwise, leave form with PSS at meeting.)	
5	***Interviewed Case Managers for TCM.***	
6	Selected Case Manager & both signed ***Case Management Selection form*** –- you and Case Manager signed it, then the Case Manager mailed or faxed form to PSS.	
7	Case Manager ***completed your Level of Care Criteria (LT-104)*** in EMWS	
8	Case Manager assisted you in ***submitting the Medicaid application to the LTC Unit*** to determine your financial eligibility.	
9	Case Manager helped you ***gather guardianship papers*** if applicable and ***additional medical documentation*** if a related condition and scanned this information into the EMWS	
10	Case Manager notified you PSS reviewed your LT-104 & LTC reviewed your financial eligibility. You will be either eligible or ineligible to proceed in your application process	
11	If eligible, TCM ***scheduled your psychological evaluation*** Date of appointment:_____ Name of licensed Psychologist:_____	
12	***Psychological evaluation completed*** by psychologist and submitted by the Case Manager.	
13	Case Manager ***completed the ICAP checklist*** in EMWS.	
14	PSS reviewed and approved your psychological evaluation, additional medical documentation if required, and ICAP checklist.	
15	***ICAP submitted to WIND to do the assessment***.	
16	WIND assessor ***schedules an interview*** to do the ICAP.	

17	Once ICAP is finalized (can take 45-90 days to complete), you are ***notified in writing by PSS that you are either eligible, on a waiting list, or you have been denied eligibility.***	
18	If ***waiting list*** letter is received, the Case Manager will continue to assist you in accessing other non-waiver services you need until the waiver funding becomes available.	
19	If eligibility letter is received and ***funding is available***, the Case Manager assists in contacting LTC staff to notify them of the funding letter and to determine your financial eligibility. Date LTC contacted: _____	
20	Applicant contacted PSS for information about service options, provider choices, and initial team meeting process information.	
21	When eligible, Case Manager assists you in interviewing potential providers for compatibility.	
22	Case Manager schedules team meeting to ***prepare your Individualized Plan of Care (IPC).***	
23	***Start receiving*** **services** offered through the Supports Waiver program and if you have needs in excess of the Supports Waiver, apply to be on the Comprehensive Waiver.	

My Notes



Wyoming Department of Health
Commit to your health.
Behavioral Health Division

Home and Community Based Services

COMPREHENSIVE WAIVER

Medicaid Waiver Application

Applicable Program

Are you currently on a waiver? ☐ Yes ☐ No
Waiver: _____

If yes, current Case Manager name:
_____

Applicant Contact Information

Applicant Name:_____

Address:_____ Mailing Address: _____

City, State, Zip: _____ City, State, Zip:_____

Phone Number: _____ E-mail address:_____

Social Security Number: _ _ _ - _ _ - _ _ _ _ DOB:_____/_____/_____

Medicaid #: __ - _____ Town to receive services:_____

Preferred method of contact? ☐ mail ☐ phone ☐ e-mail ☐ Male ☐ Female Ethnicity: _____

I am interested in the ICF/ID at the Wyoming Life Resource Center and would like more information. ☐ Yes ☐ No

Guardian Contact Information

Please fill out the following section if the person above is under 18 years of age or the person above has a legal, court-appointed guardian (full or limited).

Name of Parent(s)/Legal Guardian(s): _____

Address: _____ Phone: _____

City: _____ State: Zip: _____

E-mail address: _____
Preferred method of contact? ☐ mail ☐ phone ☐ e-mail
Is this person a legal court-appointed guardian (full or limited)? YES ☐ NO ☐

Emergency Contact Information

Please include emergency contact information.

Name: _____ Relationship to Participant:_____

Address: _____ Phone: _____

City: _____ State:_____ Zip: _____

Signatures

_____
Signature of Applicant or Legally Responsible Representative Date __/__/_____

If signature of responsible person, relationship to the applicant: ☐ Parent ☐ Guardian ☐ Grandparent ☐ Family Member ☐ Other

Signature of Witness_____ Date __/__/_____
(required if signature is marked with an "X")

Mail this form to DD Section Participant Support Specialist:

BHD Developmental Disabilities Section
6101 Yellowstone Road; Suite 220 Cheyenne, WY 82002

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Wyoming Department of Health
Commit to your health.

Behavioral Health Division

Case Management Selection

Please check the appropriate waiver:

☐ Adult Developmental Disabilities (DD) Waiver
☐ Child Developmental Disabilities (DD) Waiver
☐ Acquired Brain Injury (ABI) Waiver
☐ Comprehensive Waiver
☐ Supports Waiver

Applicant: _____
(First) (Last)

Legal Guardian: _____
(First) (Last)

Acknowledgement of Choice of Providers and Case Manager Conflict of Interest Disclosure

Please initial each line verifying services available through this waiver program have been explained to you.

_____ I understand that I have the ability to make decisions regarding what services will be provided and which providers we will work with while he/she is a waiver participant.

_____ I understand that I have a right to request informal dispute resolution or an Administrative Hearing if not given the choice of providers.

_____ I understand that I can choose a case manager not affiliated with any of my other services; however, if the case manager is providing other services on my plan or works for an organization providing me other services, this may be a conflict of interest and it must be disclosed.

Case Manager Selection

A list of DD Section certified case managers available in my region was shared with me and my questions have been answered. I have chosen the following individual to act as my case manager to assist in gathering the necessary information to prepare my clinical eligibility and, if eligible for services, to assemble and submit the Individualized Plan of Care.

I understand that I may choose a different case manager at a later date.

Case Manager Name:_____ Organization: _____

Federal Provider ID (NPI):_____ Wyoming Provider ID: _____

If this selection is to make a change, my existing Case Manager is: _____

Federal Provider ID (NPI):_____ Wyoming Provider ID: _____

Effective Date of Change to New Case Manager:_____

Consent for Information Release

Please initial each line verifying your understanding of this information.

_____ I agree to participate in assessments/screenings to determine clinical eligibility and the need for HCBS waiver services.

_____ I authorize the release of information by my physician, hospital, community mental health center, other social service providers, school, health service providers and family members to and among state agencies and their agents on my child's medical condition and other relevant information necessary to determine appropriate HCBS waiver services. I understand I may revoke this release of information in writing at any time.

Signatures

_____ __/__/_____
Signature of Applicant or Legally Responsible Representative Date

_____ __/__/_____
Signature of Selected/Current Case Manager Date

_____ __/__/_____
Signature of Witness Date
(required if the signature is marked with an "X")

_____ __/__/_____
Signature of New Case Manager Date

Mail this form to DD Section Participant Support Specialist: BHD Developmental Disabilities Section
6101 Yellowstone Road; Suite 220 Cheyenne, WY 82002